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Meeting the Needs of Mothers in Prison: An Investigation of
North Carolina's Policies and Procedures and the Nurse's Role

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April 11th, 2014

Abstract

Women make up a larger portion of the incarcerated population in North Carolina than ever before. Nearly two-thirds of women in prison are mothers. Unsurprisingly, the policies and procedures that govern the care of the general prison population are often insufficient to provide adequate care for the incarcerated mother. This paper explores the current policies and procedures that currently govern the care of incarcerated mothers and makes recommendations to address deficiencies in these standards. Improvements in prenatal care, shackling policies, and family based treatment programs could all enhance health outcomes for incarcerated mothers. In addition, this paper identifies gaps in the data and recommends additional reporting requirements to augment the state's ability to measure progress. Finally, this paper outlines the role of the registered nurse in caring for mothers while they are incarcerated and highlights the unique health needs of this vulnerable population.

Meeting the Needs of Mothers in Prison: An Investigation of North Carolina's Policies and Procedures and the Nurse's Role

Women make up a larger portion of inmates in the United States than ever before. The number of female prisoners has increased by 4.6% annually from 1995 to 2005, primarily due to the increased prosecution of non-violent drug crimes (Sentencing Project, 2007). Nearly two-thirds of women prisoners are mothers and seventy-seven percent provide the majority of care to their children prior to incarceration (Glaze & Maruschak, 2008). This leaves many children in uncertain circumstances once their mothers are incarcerated.

Women prisoners have unique health needs that need to be addressed by their prison facility. In North Carolina, the state contracts with various state-funded hospitals to provide care to the female inmates of the State of North Carolina, including antepartum, delivery, and postpartum care. This paper will focus on the care and health of incarcerated women, especially during the childbearing cycle, while highlighting North Carolina's policies and procedures in comparison to other states'.

It is important that correctional facilities be aware of the unique needs of pregnant inmates (Clarke, J., Hebert, M., Rosengard, C., DaSilva, K., & Stein, M., (2006). Caring for a woman during the childbearing cycle includes antepartum counseling, screenings, and care, care during labor and delivery, and postpartum care at the hospital, and after return to home or correctional facility. Postpartum care also may include supporting any breastfeeding practices the woman should choose to pursue and that fit the accommodations of the facility. Though it may be extremely dangerous for women in their third trimester and in the peripartum stage to be chained and restrained, many states, including North Carolina, do not have specific policies guiding the officer's use of restraints and shackles during these various levels of care, leaving

these decisions to be made by lower-level officers (Mothers Behind Bars, 2010). In addition, many states' facilities do not encourage or permit breastfeeding or the use of a breast pump (Mothers Behind Bars, 2010).

Studies show that strengthening a mother's relationship with her child through a family-based treatment program leads to reduced recidivism rates (Thompson, A., 2008). Examples of policies dictating the use of restraints, family-based treatment, and breastfeeding practices are explored below. This paper will include an analysis of North Carolina's policies regarding pregnant and parenting women and any potential effects on their children.

As with any patient, two primary facets of the nursing role are assessment and advocating. The nurse is in a position to provide better care to incarcerated mothers by recognizing their distinctive health needs and making the proper assessments. The role of the nurse also includes advocating for better care by nursing staff and all providers for their incarcerated patient.

The Female Prisoner Population

The number of women held in both state and federal prisons from 1980 to 2002 grew from 12,300 to 96,000. As shown in Figure 1, the population of female prisoners in North Carolina more than quadrupled between 1978 and 2012 (Bureau of Justice Statistics, 2013). Many of these women are charged with non-violent drug-related crimes (Mothers Behind Bars, 2010). The significant increase in the female population in prison can largely be attributed to the "war on drugs" in conjunction with mandatory minimums (Gaskins, 2004). Mandatory minimums dictate a minimum sentencing for drug crimes primarily based on the quantity of drugs involved in the case (Gaskins, 2004). These sentences do not take into account criminal

record, familial responsibilities, or that many women play a marginal role in the crime (Gaskins, 2004).

Frequently, women in prison have been the victims of physical or sexual abuse. Fifty-seven percent of women incarcerated under state jurisdiction report having been the victim of physical or sexual abuse (Sentencing Project, 2007).

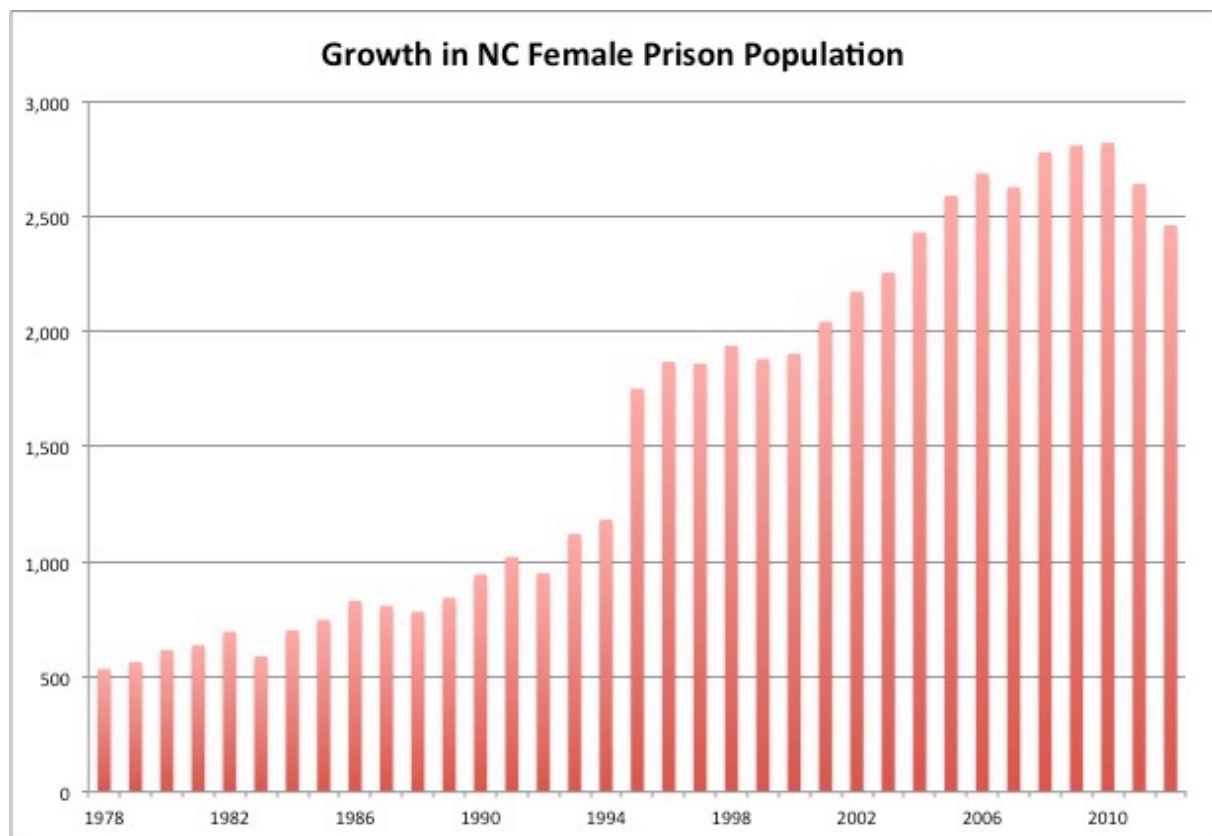


Figure 1. The Growth of the Population of Female Prisoners in North Carolina (Bureau of Justice Statistics, 2013)

Methodology

To evaluate states' current policies surrounding shackling and restraints, prenatal care, and family-based treatment, the Mothers Behind Bars State by State Report Card was referenced. The Report Card was issued in 2010. In addition to referencing the Report Card,

three attempts were made to speak with the current warden of the NC Correctional Institution for Women in Raleigh, NC about whether any of the current policies had been updated since the issuance of the Mothers Behind Bars Report Card. Each of these attempts were unsuccessful in reaching the warden, thus the information surrounding North Carolina's policies was gathered from the Mothers Behind Bars Report Card (2010) and the North Carolina Department of Corrections Rules and Policy Booklet (2010).

Prenatal Care: North Carolina's Score and Current Policies

As assigned by the Mothers Behind Bars Report, North Carolina received a grade of B in the State-By-State Report Card for prenatal care provided to pregnant inmates. North Carolina's score was based on seven factors of prenatal care. The following factors contributed positively to North Carolina's score: medical examinations are a component of prenatal care, there is standardized screening and treatment for high risk pregnancies, inmates are given prenatal nutrition counseling or the provision of appropriate nutrition, and there is a pre-existing arrangement for deliveries (Mothers Behind Bars, 2010). In addition, North Carolina requires that all women, upon admission to the North Carolina Correctional Institution for Women, be screened for HIV and other sexually transmitted infections (C. Fogel, personal communication, April 6, 2014).

A significant finding is that, according to the Mothers Behind Bars report, North Carolina correctional facilities are not required to compile a report of all pregnancies and their outcomes (2010). Research efforts also failed to reveal any such report. The absence of a comprehensive report of pregnancy outcomes makes it extremely difficult to synthesize data about the health of pregnancies within the prison system and how prison conditions may be affecting the outcomes of pregnancies.

Prenatal Care: Why It Matters

Medical examinations are critical during the antepartum period to identify health risks to both mother and child. Early identification of these problems allows earlier and more successful treatment options (Prenatal Care Fact Sheet, 2009). These check-ups, including screening for high-risk pregnancies, are even more important within incarcerated women because they are more likely to have high-risk pregnancies (Kyei-Aboagye, K.; Vragovic, O.; Chong, D., 2000). Further, women prisoners are more likely to have an infant with low birth weight and lower Apgar scores than are non-incarcerated women (Kyei-Aboagye, K. et al, 2000). Pregnant women have unique nutritional needs that should be addressed. Pregnant women need approximately three hundred more calories per day than non-pregnant women during the last six months of pregnancy (Pregnancy Fact Sheet, 2010), thus providing adequate nutrition and nutrition counseling is important.

With the increased risk of HIV and substance abuse in incarcerated women, early detection and screening is critical to this population (ACOG, 2013). Without any sort of report that compiles the outcomes of deliveries within the North Carolina prison system, the effectiveness of the prenatal care that is offered to pregnant women while incarcerated is difficult to determine.

Prenatal Care: Policy Recommendations for North Carolina

While North Carolina policies do encompass screening for HIV and other STIs and offer nutrition counseling, more action is needed in this area. The Mothers Behind Bars (2010) report suggests that North Carolina Department of Corrections should compile a yearly report that documents the outcome of pregnancies occurring within the prison system.

Shackling During Childbirth: North Carolina's Score and Current Policies

North Carolina received a score of F in the State-by-State Report Card issued by the Mothers Behind Bars report. North Carolina received this score because it has no policies specifically prohibiting the use of restraints on pregnant women (Mothers Behind Bars, 2010). While it does not consistently shackle women in labor, there is no written policy that forbids it (C. Fogel, personal communication, April 6, 2014). Currently, seven states do explicitly restrict the use of restraints throughout labor and delivery, including Colorado, New Mexico, New York, Pennsylvania, Texas, Vermont and Washington (Mothers Behind Bars, 2010).

Shackling During Childbirth: Why It Matters

The use of leg shackles during labor can be extremely dangerous to the health of a woman and her baby in the event of complications and may promote negative birth outcomes (ACOG, 2013). All mothers can experience unexpected complications during labor and delivery. Complications are more common in high-risk pregnancies, including the incarcerated population (ACOG, 2013).

Shackles should rarely, if ever, be used during pregnancy and never during labor and delivery. The American Congress of Obstetricians and Gynecologists promotes movement during labor to ease maternal pain and speed delivery (2013). This movement is restricted when a woman is shackled. Shackles also inhibit a woman's ability to catch herself if she falls, endangering both the mother and fetus. Moreover, it may be necessary to quickly shift the mother's position without inhibition if certain changes are detected, such as a change in the fetal heart rate, hemorrhage, or shoulder dystocia (ACOG, 2013).

The Association of Women's Health, Obstetric, and Neonatal Nurses issued a statement opposing the use of shackles in pregnant women, citing that it may interfere with "a nurse's

ability to adequately assess or treat pregnant women who are incarcerated. In emergency situations, such as maternal hemorrhage or abnormal fetal heart rate patterns, shackles may cause unnecessary delays in implementing potentially lifesaving measures” (AWHONN, 2011).

Shackling During Childbirth: Policy Recommendations for North Carolina

The American Council of Obstetricians and Gynecologists (2013) recommends that the least restrictive restraint be used, if any, on a woman during labor and delivery. The use of restraints during transport to and from medical facilities and while receiving medical care should be used only in exceptional circumstances on pregnant women (ACOG, 2013). The use of restraints on a woman within six weeks postpartum should only be used once approved by a medical clinician has taken into account the medical effects of such restraints (ACOG, 2013). According to ACOG, restraints on a pregnant woman should never include something that restricts leg movement or prevents the woman from breaking her fall (2013).

Some sources recommend that childbearing inmates should have the right to pursue legal action against the state if the conditions of the policy are not met (ACOG, 2013). In addition, the state should require training for any correctional officer that may be handling pregnant inmates and placing them in restraints since officers currently have no medical training on evaluating the use of restraints in pregnant women (Mothers Behind Bars, 2010).

Family-Based Treatment as an Alternative to Incarceration: North Carolina’s Score and Current Policies

North Carolina received a grade of F in the Mothers Behind Bars Report Card evaluating family-based treatment programs as alternatives to incarceration (2010). North Carolina received this score because no family-based treatment facilities exist in North Carolina (Mothers Behind Bars, 2010). Several attempts to establish such facilities in North Carolina have been

unsuccessful to date (C. Fogel, personal communication, April 6, 2014). North Carolina does operate a few programs that integrate children into the rehabilitation of the female prisoner, but none are offered as an alternative to incarceration because none of these programs have a facility that can be used for housing (C. Fogel, personal communication, April 6, 2014). Current programs available to inmates in North Carolina include the NC Inmate Maternity Leave Program and Prison MATCH (State of North Carolina Department of Corrections, 2003; National Institute of Corrections, 2013).

The Inmate Maternity Leave program allows inmates serving sentences of five years or less to take leave from their prison sentence for no more than sixty days immediately following delivery (State of North Carolina Department of Corrections, 2003). The leave period must be spent in the home of a legal family member and this must also be the caretaker of the child when the mother returns to prison (State of North Carolina Department of Corrections, 2003).

Prison MATCH is a program offered to mothers in prison serving sentences of seven years or more that also meet other requirements. In addition to normal visiting hours, women enrolled in this nine-week program are permitted extended visits with their children in a home-like apartment setting on the prison campus. The apartment includes a fully stocked kitchen, toys, and a living room. Mother and child can spend quality time for up to three hours (National Institute of Corrections, 2013).

Family-Based Treatment as an Alternative to Incarceration: Why It Matters

Family-based treatment has been shown to reduce recidivism in inmates, decrease the chance that an inmate's children will become incarcerated, and improves developmental progress of the inmate's children (Thompson, 2008). Family-based treatment is appropriate for incarcerated mothers because incarcerated mothers are more likely to be in prison for non-violent

crimes (Sentencing Project, 2007), thus making them a lower risk to society. Family-based treatment has many advantages, including allowing the mother and child to interact in an environment that is more realistic to a home setting than prison. A lack of family-based treatment frequently means that a family is torn apart and a healthy parent-child relationship isn't formed during childhood.

Since mothers are frequently the primary caregivers of their children, maternal incarceration adversely affects children and families. Women in prison were five times more likely than men in prison to have a child removed from their immediate family and placed in a foster home or other agency (Sentencing Project, 2007). Even when children are left with immediate family members, statistics show that the majority of parents in state prisons are held over one hundred miles from their prior residence (Sentencing Project, 2007), making it even more difficult for caregivers to foster visitation and maternal involvement. When surveyed in 1999, over half of women held in state prisons had never had a visit from their child, while one in three had never spoken by phone with their child (Sentencing Project, 2007). Existing legislation known as the Adoption and Safe Families Act of 1997 may in fact be destructive to families with an incarcerated parent. The law hastens the termination of parental rights to provide for faster adoptions, allowing many states to initiate termination of parental rights when the child has been in foster care for fifteen of the last twenty-two months (Sentencing Project, 2007).

Family-Based Treatment as an Alternative to Incarceration: Policy Recommendations for North Carolina

Based on the research findings cited in the policy review, I recommend a policy for North Carolina that allows for a comprehensive family-based treatment program for women who

have committed a non-violent crime and have no history of child abuse. The program would have similar qualifications to those of the Prison MATCH program (National Institute of Corrections, 2013). The program would allow mothers and children to stay together in the same facility, thus enhancing their relationship through treatment and services, rather than further distancing them from each other and further damaging the maternal-child relationship.

The program could be compared to the Tamar Village Program that provides comprehensive family-based treatment in Los Angeles, California (Icenhower, 2011). The Tamar Village provides housing for mothers and children to cohabitate while mothers receive therapeutic services Monday through Friday on topics such as nutrition, HIV/AIDS risk reduction, domestic violence, sexual abuse, grief and loss. The Village also provides an on-site developmental child center and youth program for older children (Icenhower, 2011). As a result of programs such as Tamar Village, women are less likely to lose their children to foster care or adoption, mothers more easily re-integrate into the community, and recidivism is reduced (Icenhower, 2011). Thirty-two states, including California, are currently sentencing mothers to family-based treatment programs as alternatives to incarceration (Mothers Behind Bars, 2010).

Family-based treatment may also be focused more around the childbearing cycle. A community-based residential program established in 1990 allowed pregnant women with short-term sentences to live in the community during pregnancy and reside with their infants after birth. While in the program, a wide array of services were provided, including prepared childbirth instruction, drug treatment, in-labor assistance, infant rooming in, lactation consultation, overnight visitation by other children, birth control counseling, employment assistance, career planning, aftercare and follow-up (Barkauskas, V.; Kane Low L.; Pimlott, S.; 2002). The findings of the program showed that compared women in traditional prisons, women

responded positively to the community-based setting and were more likely to have a low-birth weight baby than those in a residential community-based program (Barkauskas, V. et al, 2002).

The Health Needs of Women in Prison

Given the fast growing population of women in prison, it is important that North Carolina create necessary policies that ensure appropriate care for the female inmate. According to a 1992 study, women in prison are more likely to have depressive symptoms than women not in prison (Fogel & Martin). Mothers in prison were more likely to maintain signs of a higher level of anxiety throughout a prison stay, while the signs of anxiety in non-mothers decreased (Fogel, Martin, 1992).

Reproductive health needs are also extremely important to incarcerated women and the criminal justice system. A 2006 study revealed that women in prison are at a higher risk for STIs and pregnancy. Of 484 women, 66.5% had inconsistent birth control use and 80% had inconsistent condom use. More than 80% had experienced unplanned pregnancies (Clarke J., et al, 2006)

The Nurse's Role

Nurses interact with prisoners within the prison system and also when Department of Corrections facilities contract with outside hospitals to care for inmates. The nurse has an important role in caring for the mother in prison. Sometimes a nurse may bring biases towards an incarcerated patient. However, nurses must remember that, according to the American Nurses Association Code of Ethics, "The nurse respects the worth, dignity and rights of all human beings irrespective of the nature of the health problem. (ANA Code of Ethics, 2001)." Further guidance is provided by the Code of Ethics in provision 2.2, "Nurses must examine the conflicts arising between their own personal and professional values... as well as those of patients. Nurses

strive to resolve such conflicts in ways that ensure patient safety, guard the patient's interests and preserve the professional integrity of the nurse (ANA Code of Ethics, 2001).

In the perinatal setting, it is the nurse's responsibility to advocate for her patient as he or she would for any non-incarcerated patient. Shackles and restraints are dangerous to a childbearing women's health and the use should be restricted if not limited during labor, delivery, and postpartum bonding. The nurse should advocate for the least restrictive setting while maintaining patient and caregiver safety, to optimize health of both mother and baby. If necessary, the nurse should seek and advocate for documentation from the medical provider to further justify decreasing the use of restraints or shackles.

In addition, the nurse should encourage skin-to-skin contact with the newborn after delivery if appropriate and desired by the mother and assess the patient's desire for contraception. The nurse caring for an incarcerated woman in any hospital or clinic setting should be aware of the medical conditions most likely affecting women in prison. Nurses should thoroughly assess the patient for psychological issues and consult with the team on making appropriate follow-up recommendations for care. The nurse should understand the psychological and physiological consequences of incarceration and the unique effects this may have on an incarcerated mother.

Conclusion

North Carolina has strong programs for both identifying and treating HIV and other sexually transmitted infections. Its Mothers and Their Children program provides parenting classes that benefit both the incarcerated mother and her children. But, the state could still make improvements in prenatal care, shackling policies, and family-based treatment. Reporting

pregnancy outcomes would allow the state to more accurately track its progress in enhancing the health of incarcerated mothers.

The registered nurse plays a critical role in advocating for the incarcerated mother within this system. The woman's status as a prisoner does not change the need for freedom of movement during labor or reduce the importance of maternal-child bonding practices, such as skin-to-skin contact after delivery. The nurse's role as a patient advocate requires that he or she leave any biases behind and advocate for these women as they would any other patient.

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